

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-008314

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2269

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED MAR 8 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4339 Enright Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) George Bell		4. DATE OF DEATH Month 1 Day 18 Year 63	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-22-79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 83 IF UNDER 1 YEAR: Months Days IF UNDER 24 HR: Hours Min.
11a. FATHER'S NAME George Bell		11b. MOTHER'S MAIDEN NAME Sophia Rogers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. UNK	
17. INFORMANT Mrs. Mary D. Jett, R.R.L., 2601 N. Whittier		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Fibrosis		INTERVAL BETWEEN ONSET AND DEATH Undet.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 525X DUE TO (c)			

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	

21. I attended the deceased from 1-5-63 to 1-18-63 and last saw him alive on 1-18-63 Death occurred at 8:30 P. on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>J. H. Whittier</i>		22b. ADDRESS 2601 N. Whittier		22c. DATE SIGNED 1-23-63	
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23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2-28-63		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
23d. LOCATION (City, town, or county) St. Louis, Mo.		23e. DATE RECD. BY LOCAL REG. FEB 28 1963		23f. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i>	

24. FUNERAL DIRECTOR Rowland Aker Mortuary Service 4104 Manchester Ave. St. Louis 10, Mo.	
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MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

1

2 *2/19*

3

4 *2*

5 *9*

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7 *1*

8 *2*

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11

12 *77-0*

13

77

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.